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ABSTRACT

In 1988, Franklin County Children Services in Columbus, Ohio, initiated the development of a community-based, multidisciplinary process to review all deaths of children on its open caseload, and deaths in cases in which the agency had contact with the child or the child's family in the 12 months preceding the child's death. The review process enables the community to identify problems in the service delivery system that are related to child deaths, and to eliminate preventable deaths by enhancing the quality of services and programs. The process also identifies and tracks causal trends in deaths of children. During 1989, 1990, and 1991, the largest proportion of children died as a result of perinatal conditions or congenital defects. The 1990 infant mortality rate for Franklin County was 10.8 deaths per 1,000 live births, with the rate significantly higher for black infants. The percentage of women receiving delayed prenatal care increased between 1988 and 1989, with black women more than twice as likely than white women to receive late prenatal care. Many areas targeted for action in 1992 involved increasing the availability of prenatal care and promoting public awareness of its importance. Key program changes and accomplishments have included revised investigatory policies; in-service training for all staff related to child death risk factors; an increase in staffing and services of various units; and a variety of collaborative activities and revised protocols and practices. An infant service delivery protocol is appended. (AC)

DECEASED CHILD REVIEW PROCESS: A FOUR-YEAR PERSPECTIVE

Presented at

NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE
22ND ANNUAL CONFERENCE

"OUR CHILDREN MILES TO GO, PROMISES TO KEEP"
September 17-19, 1992
Washington, D.C.

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Special recognition must be given to the Franklin County Coroner's Office, the Columbus Police Department, and the Columbus Health Department for their special partnership with Franklin County Children Services in system redesign.

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ABOUT FRANKLIN COUNTY CHILDREN SERVICES

Franklin County Children Services (FCCS) in Columbus, Ohio, is the public, county-wide agency responsible for the **care and protection of abused, neglected, dependent and troubled children**. In 1991, 23,718 children and families were served through a Children Services tax levy that supports the operations of FCCS and the purchase of services from 57 community agencies. FCCS provides a comprehensive array of services, including:

- 24-hour hotline to report abuse and neglect of children;
- investigation of child maltreatment and crisis intervention for children in need;
- protective in-home counseling and supportive services to children and families;
- placement in out-of-home care for children in need of temporary foster home care, permanent adoptive homes or independent living situations;
- prevention programs for high-risk children and families; and
- services to children with medical handicaps.

In 1991, FCCS's expenditures were $53,803,950. Of that amount $25,029,275 was spent to provide placement away from home for children in need; $20,932,962 was spent to provide protective in-home services to children living with their families; $5,306,422 was spent to investigate suspected child maltreatment; $1,376,461 was spent to provide prevention services to keep children off the FCCS caseload; and, $1,158,830 was spent to provide services to children with medical handicaps. The 1992 Budget is $61.7 million of which about 80 percent is from local property taxes, 15 percent Federal and 5 percent from the State.

FCCS is governed by an 11-member board, employs 740 persons, is regulated by mandates of the state and federal government, and fully accredited by the Council on Accreditation of Services for Families and Children. FCCS is one of seven County Children Services Boards in Ohio to be accredited by the Child Welfare League of America and one of twenty-five in the nation.

FCCS CLIENT DEMOGRAPHICS

As of June 30, 1992, FCCS had 6606 children from 3,322 families open and receiving services. Fifty-one percent of these children are African-American, and 35 percent are age five and under. This is the highest caseload the Agency has experienced (in the same time frame) since 1978. It reflects increasing reports of abuse and neglect. In the first eight months of 1992, there were 4,611 new complaints of neglect and abuse received. This compares to 3,413 new referrals during the same time frame for 1991, a 35 percent increase.

With increased referrals have come increased case openings. Case openings for neglect are 46 percent higher in the first half of 1992 than in the first half of 1991, and for abuse are 20 percent higher in the same time frame.

Compared to 1991, the number of children coming into substitute care is holding stable. But the number of very young children coming into care is increasing. Entrances into foster home care have increased by 36 percent.

BACKGROUND

In 1988, Franklin County Children Services (FCCS) initiated the development of a bi-level, community-based, multi-disciplinary process to review all deaths of children on its open caseload, as well as deaths where the Agency had contact with the child/family in the twelve months preceding death. 1992 marks the fifth year of operations for the Franklin County Deceased Child Review System. See Appendix A for a description of the review process.

With the strong support and involvement of twenty other local agencies, FCCS maintains a review process which enables the community to identify systems problems and deficits related to child deaths and to work collaboratively to resolve identified issues thereby eliminating preventable child deaths, not just those attributed to maltreatment.

The review process also identifies and tracks causal trends in deaths of children which helps prioritize, link and focus community resources when expedient, and supports development of program initiatives designed to impact on top priority problem areas.

The review process recognizes and affirms good practice, standards, and programs and is an excellent tool for ensuring that issues related to child death are reviewed in a systematic and timely manner. It is only by reviewing "worst case" situations are we able to identify issues and work to make necessary changes throughout the entire child-serving community.

Two key principles underlie the deceased child review process:

- Child death is a community-wide issue and concern—not just that of child protective service agencies.

- Prevention of future deaths through quality enhancement of services, programs and systems is the desired result from the review process—not negative sanctions against individuals or agencies. Separate, existing procedures are used to determine if disciplinary or other punitive actions are warranted in particular instances of child deaths.

Key results obtained after four years of use are:

- An established, consistent process for review of child deaths for both agency staff and the community. The community is assured that the collective results of these reviews are made public annually.

- Specific program and systems changes designed to reduce preventable child deaths.

- Strong multi-agency support for the review process, resulting in improved community planning and programs.

- Comprehensive data available for use in planning and refining the county child-serving system.

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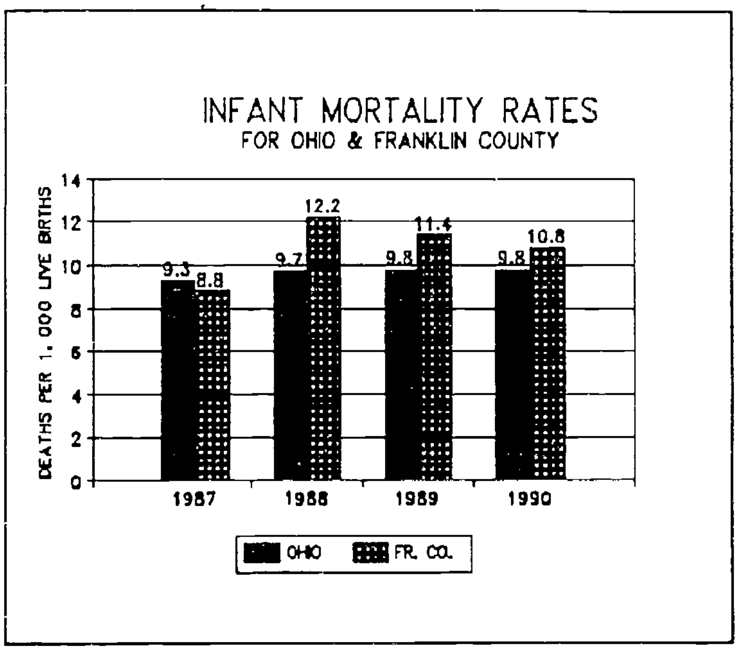
- Public education so that families are more aware of child safety issues and needs.

ACTION PLANNING 1992

The largest proportion of children died as a result of perinatal conditions or congenital defects. The majority of these children died before reaching six months of age (87 %) which is similarly comparable with data presented for 1989 and 1990. This information is consistent with that of the Columbus Health Department which indicates that the county infant mortality rate has not significantly declined. According to the Columbus Health Department, the 1990 infant mortality rate for Franklin County remained at 10.8 deaths per 1000 live births. When categorized racially, the infant mortality rate was significantly higher for Black infants.



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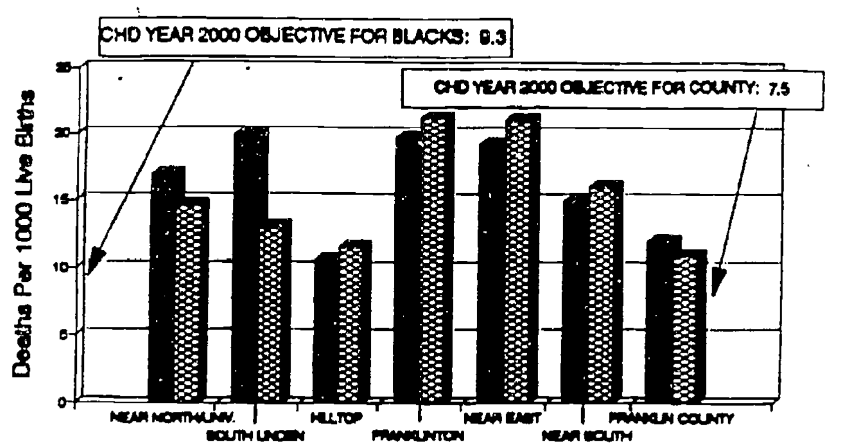
The Columbus Health Department indicates that the infant mortality rate is generally regarded as a quality of life indicator of both the health and welfare of a population. A high rate indicates not only unmet health needs but also unfavorable conditions such as poverty, poor nutritional status, lack of education, poor sanitation and alcohol and other drug use. (Deborah Crawford, Columbus Health Department)

According to a report completed by the Children's Defense Fund in 1991, Ohio's infant death rate remained at 9.8 in 1990 meaning that over 1,600 babies died across the state before reaching one year of age. Prenatal care for pregnant women actually worsened from 1988 to 1989, as the percentage of pregnant women receiving delayed care increased. In 1989, nearly 30,000 Ohio babies were born to mothers who did not receive early prenatal care (18.1%). This corresponded to 16.3% in Franklin County. Many of these women were receiving public assistance and faced overcrowded public clinics, physician shortages and transportation problems. Black women were 2.1 times more likely than white women to receive late prenatal care.

Of further consideration when discussing the high number of infant deaths during the first six months of life are the infant mortality rates by neighborhoods which can loosely be compared to the FCCS service regions.

INFANT DEATH RATES, 1980-84 & 1985-89

Selected Community Areas*



*These areas were selected because they contain CFHS and other neighborhood clinics.

Franklin County Child & Family Health Services
Prepared by Deborah Crawford, Columbus Health Department, 7/91

The Near East and Near South neighborhoods can be compared with the FCCS South Region. Near North/Univ. and South Linden can be roughly equated with the FCCS North Region. Franklinton would roughly compare to the eastern inner-city portion of the FCCS West Region.

The above statistics concur with results obtained from the forty-four reviews completed during 1991. The majority of deaths were the result of perinatal/congenital conditions and of children under one year of age. Also of significant concern are the deaths as a result of violence-homicide. Most of these deaths were preventable given different circumstances and the availability or accessibility of services.

The following areas are targeted for action in 1992:

- Assure that all pregnant women have available and receive prenatal care as early as possible to reduce premature and low-birthweight babies. The community must continue to work towards a solution which addresses infant mortality, particularly among Black infants, with expanded services and resources prenatally, particularly for minor and drug/alcohol abusing mothers.

- Target the central city area for a public awareness campaign of the value of early prenatal care and risks to the developing fetus when alcohol and drugs are used prenatally.

- Expand outreach and home visitation programs to pregnant women, particularly in the central city area.

- Implement the High-Risk Infant Protocol county-wide to include all maternity hospitals and health departments. FCCS implement internally the Infant Service Delivery Protocol.

- Develop a community-based medical program which provides intensive prenatal medical and social services care to drug/alcohol abusing mothers.

- Continued development and implementation of conflict resolution teams within the schools.

- Initiate work with all youth and families in inner-city neighborhoods with a focus on the reduction of violence by utilization of conflict resolution techniques, neighborhood violence prevention programs, programs to enhance parenting skills and to heighten self esteem.

KEY CHANGES AND ACCOMPLISHMENTS TO DATE

- Revised investigatory policies that all FCCS first contacts related to abuse and neglect allegations be made in person.
- Collaboration on a multi-agency High-Risk Infant Protocol by FCCS and the Columbus Health Department including plans for a hospital-based pilot project with eventual community-wide use.
- Expansion of the Employee Assistance Program to include grief counseling to foster parents experiencing problems as a result of a child death.
- Automatic referral to the Employee Assistance Program for staff who have a child death occur on their caseload.
- In-service training for all staff related to child death risk factors.
- Coordination of training resources between Franklin County Children Services and the Columbus Health Department.
- Development of an Infant Services Delivery Protocol which acknowledges the high-risk status of infants and which identifies mandated, additional services to be provided to all infants six months of age or younger and their families who are open for services with FCCS.
- A signed inter-system risk referral protocol between FCCS Intake and Investigation Department and seven major community hospitals.
- Improved format for the Deceased Child Case Staffing Reports and the dissemination of recommendations for program or system changes.

- Location of a Public Health Nurse at Intake and Investigation with additional contractual 24-hour backup.

- Development and implementation of a Family Assessment and Development Department with a focus on early assessment and provision of intensive services immediately.

- Location of a Columbus Health Department Public Health Nurse on site at all four FCCS Region offices one day a week for consultation, education and medical risk assessment.

- FCCS funding of six prevention grants to local agencies in 1991 and 1992 which specifically address the needs of high-risk infants and their families:

    Columbus Health Department-Family Ties;
    Diocesan Child Guidance Center-Step by Step;
    Gladden Community House-Nurturing Teens for Positive Parenting;
    Children's Hospital-Improving Parent and Child Skills in a High-Risk Population;
    Lamaze Child Birth Organization-Parent Teen Program; and
    Rosemont Center-Baby Day Care

- Increased home-based services developed by agencies with whom FCCS contracts; currently there are 15 contracts for home-based teams.

- Appointment of a CHD Public Health Nurse administrator to the FCCS Board's Program & Services Committee to support contemporary program development for high-risk children and their parents.

- Expansion of the number of professionals involved with the Deceased Child Review Team to include a neonatal pathologist and Central Ohio SIDS representative.

- Reviewed and adopted data information forms for use in 1992 Team review of all child deaths via death certificates.

- Instituted a working agreement for all child deaths under age one to be linked with birth records to determine prenatal information crucial to future community action planning.

- The Ohio Department of Human Services recommended (November, 1988) that other Ohio counties use the FCCS model in setting up an internal child death review system.

- The House of Representatives Select Committee on Child Abuse and Juvenile Justice (Boggs Report, March, 1989) recommended that Ohio counties develop child death review models similar to the FCCS system.

- Selection by the American Bar Association of the 1990 Deceased Child Review System Report for inclusion in a Child Maltreatment Fatalities "how-to" manual available to state and local agencies.

- The Franklin County Deceased Child Review System has been presented at several national and local conferences providing exposure for this model and its focus on coordinated community efforts to improve systems impact in child protection.